

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11219

CERTIFICATE OF DEATH

Reg. Dist. No.

11200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural near - Calvert</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural near - Calvert</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i> | | d. STREET ADDRESS <i>1/4 mi. E. of Rising Sun</i> | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Annie</i> | First <i>Mary</i> | Middle <i>Barber</i> | Last 4. DATE OF DEATH <i>Oct. 31 1958</i> |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>6/9/1864</i> |
| 9. AGE (In years last birthday) <i>94 yrs.</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | 11. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | 12. CITIZEN OF WHAT COUNTRY? <i>Cecil, Md USA</i> |
| 13. FATHER'S NAME <i>John Thomas Davis</i> | 14. MOTHER'S MAIDEN NAME <i>Katherine Lake</i> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>432.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) <i>Arterio slerosis.</i> <i>Infected Mouth & legs.</i> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>9-20</i> , 19 <i>58</i> , to <i>10-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10-20</i> , 19 <i>58</i> , and that death occurred at <i>6434 M</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>R.C. Dodson, M.D.</i> | ADDRESS (Street, city or town, state) <i>Rising Sun, Md</i> | | |
| PHYSICIAN'S NAME (Type) <i>R.C. Dodson, M.D.</i> | DATE SIGNED <i>10/31/58</i> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>11/3/58</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Bank</i> | 22d. LOCATION (City, town, or county) (State) <i>Calvert, Cecil, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed, Rising Sun, Md.</i> | ADDRESS <i>101 Main Street, Rising Sun, Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>10/31/58</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Moore</i> |

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INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11201

11220 CERTIFICATE OF DEATH

Reg. Dist. No.

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|---|-------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH COUNTY Cecil CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rising Sun, Rural | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rising Sun, Rural | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | LENGTH OF STAY (to this place) 6 yrs. | | |
| 3. NAME OF DECEASED (Type or Print) Mary Ann Baxter | | | 4. DATE (Month) OF DEATH Oct. 10 (Day) (Year) 1958 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH Oct. 28, 1873 | 9. AGE last birthday 85 84 yrs. | IF UNDER 1 YEAR Months 1 Days 0 Hours 0 Min. 0 |
| 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) England | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13. FATHER'S NAME Jesse Burroughs | | | 14. MOTHER'S MAIDEN NAME Ellen Clark | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. 220-14-7547D | | 17. INFORMANT & ADDRESS Mrs. Wm. R. Edmondson Rising Sun Md. | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Ztantis Arteriosclerosis severe GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) Rising Sun (State) Md. | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from 5-25-56 , 19....., to 10-8-58 , 19....., that I last saw the deceased alive on 10-8-58 , 1958 and that death occurred at 1-15 PM , from the causes and on the date stated above. SIGNATURE Wm. R. Edmondson ADDRESS Rising Sun, Md. DATE SIGNED 10-11-58 | | | | | |
| 23. BURIAL-CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Oct. 13 1958 | | NAME OF CEMETERY OR CREMATORIAL Ebenezer Cem. LOCATION (City, town, or county) (State) Rising Sun, Md. | |
| 24. REC'D BY REGISTRAR DATE OCT 14 '58 | | REGISTRAR'S SIGNATURE Carrie S. Kline | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl T. Myers Rising Sun, Md. | |

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11. *U. S. Fish Commission, 1881-1882*

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11221

CERTIFICATE OF DEATH

Reg. Dist. No.

11202

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| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | b. COUNTY Harford | |
| c. LENGTH OF STAY IN 1b 16 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V. A. Hospital | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 12 X-2 | |
| 3. NAME OF DECEASED (Type or print) FRANK | | First (N.M.) | Middle BIRTHWISTLE |
| 4. DATE OF DEATH October | | Month 25 | Day Year 1958 |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-21-95 | |
| WIDOWED <input type="checkbox"/> | | DIVORCED <input type="checkbox"/> | |
| 9. AGE (In years last birthday) 63 years | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tourist Camp Owner | | 10b. KIND OF BUSINESS OR INDUSTRY Private | |
| 11. BIRTHPLACE (State or foreign country) Clifton Heights, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FRANK BIRTHWISTLE | | 14. MOTHER'S MAIDEN NAME PRESCILLA SUTTON | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 17. INFORMANT 164-07-9264 VA Hospital Records, Perry Point, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| 592X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic glomerulonephritis. | | DUE TO Unknown | |
| DUE TO (c) | | Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-9-1958, to 10-25-1958, and that death occurred at 3:30 AM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 10-25-58 | |
| ACTUAL SIGNATURE J. C. Grasberger, M.D. | | M.D. VAH, Perry Point, Maryland | |
| PHYSICIAN'S NAME (Type) J. C. GRASBERGER, M.D. Acting Director, Professional Services. | | 22. BURIAL, CREMATION, REMOVAL (If any) 10-28-58 | |
| 22b. DATE THEREOF 10-28-58 | | 22c. NAME OF CEMETERY OR CREMATORIAL Centre Cemetery | |
| 22d. LOCATION (City, town, or county) Forest Hill, Maryland | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE FOSTER FUNERAL HOME, Bel Air, Maryland | | 24a. REGD. BY REGISTRAR OCT 28 58 DATE | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE C. M. S. M. M. | |

BY PROPHETIC WORD FROM THE HOLY SPIRIT

INTRODUCED IN 1823



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8, File G234, 10/10/58 fcy
11222 CERTIFICATE OF DEATH

11203
97

Reg. Dist. No.

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|--|--|--|--|---|---|--|--|----------------------|------------|-------------|------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Cecil | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit | | d. STREET ADDRESS 13 Barton Road, Manor Heights | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Arthur | | First | Middle | Last | 4. DATE OF DEATH Bostwick | Month October | Day 6 | Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5 October/1958 | | 9. AGE (In years lost birthday) yrs. 22 | IF UNDER 1 YEAR IF UNDER 24 HRS. Months 22 | | Days 42 | Hours 22 | Min. 42 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States | | | | | |
| 13. FATHER'S NAME Arthur Paul Bostwick | | 14. MOTHER'S MAIDEN NAME Mary Anne Lowry | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Hospital Record | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X | | PREMATURITY | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u> | | (b) DUE TO | | | | | | | | | |
| | | (c) DUE TO | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | Month 19 | Day 19 | Year 1958 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Colora | (County) Maryland | (State) | | |
| 21. I certify that I attended the deceased from 6 October, 1958, to 6 October, 1958, that I last saw the deceased alive on 6 October, 1958, and that death occurred at 6:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | | | | | |
| ACTUAL SIGNATURE James K. Fugate | | M.D. | | U. S. Naval Hospital, Bainbridge, Md. 10/8/58 | | | | | | | |
| PHYSICIAN'S NAME (Type) JAMES K. FUGATE, I.T. MC USNR | | | | | | | | | | | |
| 22a. BURIAL/CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/8/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM West Nottingham Cemetery | | 22d. LOCATION (City, town, or county) Colora, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son | | ADDRESS PERRYVILLE, MD. | | 24a. REC'D BY REGISTRAR OCT 9 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Trahan | | | | | |

CERTIFICATE OF DATA

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 8010 | 8011 | 8012 | 8013 | 8014 | 8015 | 8016 | 8017 | 8018 | 8019 | 8020 | 8021 | 8022 | 8023 | 8024 | 8025 | 8026 | 8027 | 8028 | 8029 | 8030 | 8031 | 8032 | 8033 | 8034 | 8035 | 8036 | 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80420 | 80421 | 80422 | 80423 | 80424 | 80425 | 80426 | 80427 | 80428 | 80429 | 80430 | 80431 | 80432 | 80433 | 80434 | 80435 | 80436 | 80437 | 80438 | 80439 | 80440 | 80441 | 80442 | 80443 | 80444 | 80445 | 80446 | 80447 | 80448 | 80449 | 80450 | 80451 | 80452 | 80453 | 80454 | 80455 | 80456 | 80457 | 80458 | 80459 | 80460 | 80461 | 80462 | 80463 | 80464 | 80465 | 80466 | 80467 | 80468 | 80469 | 80470 | 80471 | 80472 | 80473 | 80474 | 80475 | 80476 | 80477 | 80478 | 80479 | 80480 | 80481 | 80482 | 80483 | 80484 | 80485 | 80486 | 80487 | 80488 | 80489 | 80490 | 80491 | 80492 | 80493 | 80494 | 80495 | 80496 | 80497 | 80498 | 80499 | 80500 | 80501 | 80502 | 80503 | 80504 | 80505 | 80506 | 80507 | 80508 | 80509 | 80510 | 80511 | 80512 | 80513 | 80514 | 80515 | 80516 | 80517 | 80518 | 80519 | 80520 | 80521 | 80522 | 80523 | 80524 | 80525 | 80526 | 80527 | 80528 | 80529 | 80530 | 80531 | 80532 | 80533 | 80534 | 80535 | 80536 | 80537 | 80538 | 80539 | 80540 | 80541 | 80542 | 80543 | 80544 | 80545 | 80546 | 80547 | 80548 | 80549 | 80550 | 80551 | 80552 | 80553 | 80554 | 80555 | 80556 | 80557 | 80558 | 80559 | 80560 | 80561 | 80562 | 80563 | 80564 | 80565 | 80566 | 80567 | 80568 | 80569 | 80570 | 80571 | 80572 | 80573 | 80574 | 80575 | 80576 | 80577 | 80578 | 80579 | 80580 | 80581 | 80582 | 80583 | 80584 | 80585 | 80586 | 80587 | 80588 | 80589 | 80590 | 80591 | 80592 | 80593 | 80594 | 80595 | 80596 | 80597 | 80598 | |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|----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1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item No. 11207, 10-27-58

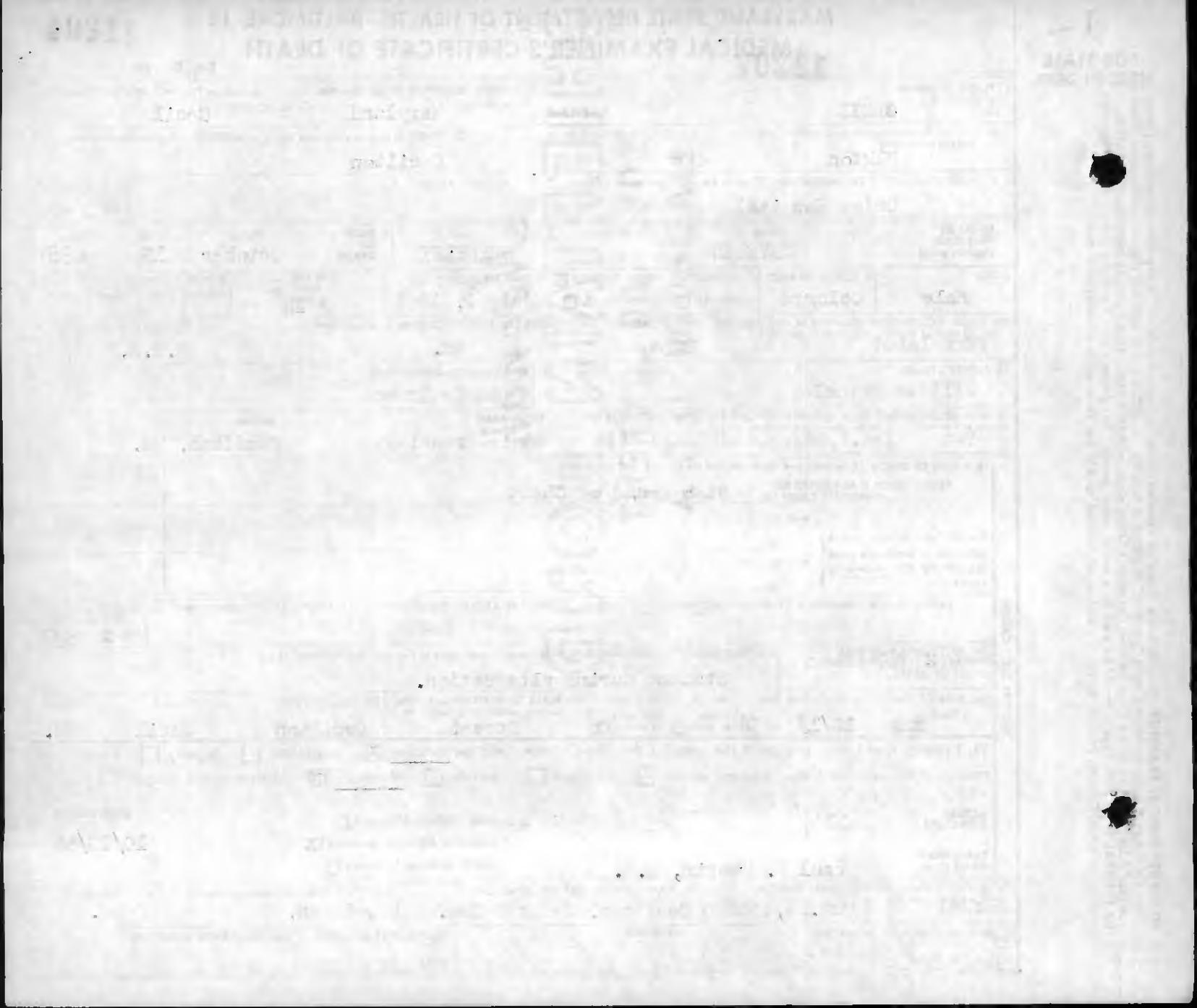
11204

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY CECIL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) RAYMOND | | First RAYMOND | Middle BRINKLEY |
| 4. DATE OF DEATH October 19 1958 | | Lost BRINKLEY | Month October |
| 5. SEX Male | | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH July 1, 1932 | | 9. AGE (In years from birthday) 26 | 10. IF UNDER 1 YEAR Months 2 Days 1 Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Brinkley | | 14. MOTHER'S MAIDEN NAME Addie Harmon | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. Jan. 7, 53 Jan. 655213-30-0016 | 17. INFORMANT Addie Brinkley, Address Cecilton, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 982X | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Stab Wound of Chest | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Stabbed during altercation. | |
| 20c. TIME OF INJURY Month, Day, Year Hour 10/19 1958 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street |
| | | 20f. (City or town) Cecilton | (County) Cecil |
| | | (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Paul F. Guerin</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | DATE SIGNED 10/20/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 22, 1958 | 22c. NAME OF CEMETERY OR CREMATORIAL Cecilton, Colored Cem. |
| 22d. LOCATION (City, town, or county) Cecilton | | (State) Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Wellington, Md.</i> | | ADDRESS <i>Wellington, Md.</i> | 24a. REC'D BY REGISTRAR DATE OCT 23 '58 |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. French</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health in its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11223

CERTIFICATE OF DEATH

11205

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MD. | | b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising, Sun, Rural | | c. LENGTH OF STAY IN 1b 2 wks. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, Maryland, R.B. | | d. STREET ADDRESS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Nursing Home | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First Matilda | Middle Josephine | Last Chambers | 4. DATE OF DEATH | Month October | Day 28, 1958 | Year |
| S. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH January 4, 1885 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months 0 | IF UNDER 24 HRS. Days 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) Minnesota | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Louis Meyer | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Magley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, unknown) No | | 16. SOCIAL SECURITY NO none | | 17. INFORMANT Ernest W. Chambers | | Address Rising Sun, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 32/X DUE TO Pneumonia | | | | 3 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO cerebrovascular accident | | | | 3 wks. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/1 , 19 58 , to 10/28 , 19 58 , that I last saw the deceased alive on 10/28 , 19 58 , and that death occurred at 3 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Neil Taylor Jr. | | | | ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 10/28/58 | | | |
| PHYSICIAN'S NAME (Type) Neil Taylor Jr. | | Rising Sun, Md. | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 2/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Zion Cem. | | 22d. LOCATION (City, town, or county) Bertha - Minn. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Taylor, Rising Sun, Md. | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE OCT 3 1 '58 | | 24b. REGISTRAR'S SIGNATURE Anna S. House | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11206

11208

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | | |
|---|--|---|--|--|---------------------------------|--|-----------|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. | | b. COUNTY Cecil | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etkton | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural | | d. STREET ADDRESS Cokesbury | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Infant | | First | Middle | Last | 4. DATE OF DEATH Clark | Month 10 | Day 19 | Year 1958 | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-19-1958 | | 9. AGE (in years lost birthday) yrs. Months 6 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours 6 | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | |
| 13. FATHER'S NAME Hezekiah | | Clark | | 14. MOTHER'S MAIDEN NAME Adeline | | Cain | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Hezekiah Clark, Port Deposit, Md. Rural | | Address | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. | | b. Pulmonary Atlectasis | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs. | | | | | | | | |
| (b) | | DUE TO Prematurity - 32 wks. gestation | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| 19. MEDICAL CERTIFICATION | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from 19 Oct 1958, to 20 Oct 1958, that I last saw the deceased alive on 19 Oct 1958, and that death occurred at 1 A.M. from the causes and on the date stated above. | | | | | | | | | | | | | | ADDRESS (Street, city or town, state) |
| ACTUAL SIGNATURE Hlaus H. Huchner | | M.D. | | No. 16 East, Ed. | | | | | | | | | | DATE SIGNED 30 Oct '58 |
| PHYSICIAN'S NAME (Type) Hlaus H. Huchner M.D. | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL Burial Oct. 21, 1958. | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORIAL Cokesbury Cem. | | 22d. LOCATION (City, town, or county) Port Deposit, Md. Rural | | | | | | | | (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE Vera Patterson-Lyon | | ADDRESS Perryville, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 22 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11209

CERTIFICATE OF DEATH

11207

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| | | | | | | | | |
|---|---------------------------|--|---|---|-------------------------------------|--|----------------------------------|--------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | b. COUNTY Cecil | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | d. STREET ADDRESS 246 E. Main Street | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First Florence | Middle Perkins | Last Davis | 4. DATE OF DEATH Oct | Month 6 | Day 6 | Year 1958 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH July 4, 1890 | 9. AGE (In years at birth) 68 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner | | 10b. KIND OF BUSINESS OR INDUSTRY Hardware | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Charles Perkins | | | | 14. MOTHER'S MAIDEN NAME Laura Maxwell | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) No | | 16. SOCIAL SECURITY NO 217-36-3883 | | 17. INFORMANT J. Charles Davis | | Address Elkton, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any: (b) DUE TO lying cause lost. (c) | | Particulars of death of Esophagus | | | | INTERVAL BETWEEN ONSET AND DEATH June 1958 | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) | 20f. (City or town) Elkton | (County) | (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 6</u> , 1958, to <u>Oct. 6</u> , 1958, that I last saw the deceased alive on <u>Sept. 6</u> , 1958, and that death occurred at <u>Elkton</u> , Md., from the causes and on the date stated above. ACTUAL SIGNATURE <u>Donald J. Spreeker</u> , M.D. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED <u>Oct. 6, 1958</u> | | | | | | | | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/8/58 | | 22c. NAME OF CEMETERY OR CREMATORIUM Elkton Cemetery | | 22d. LOCATION (City, town, or county) Elkton, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u> | | ADDRESS Elkton, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 14 '58 | | 24b. REGISTRAR'S SIGNATURE <u>Charles J. Krause</u> | | |



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-510M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

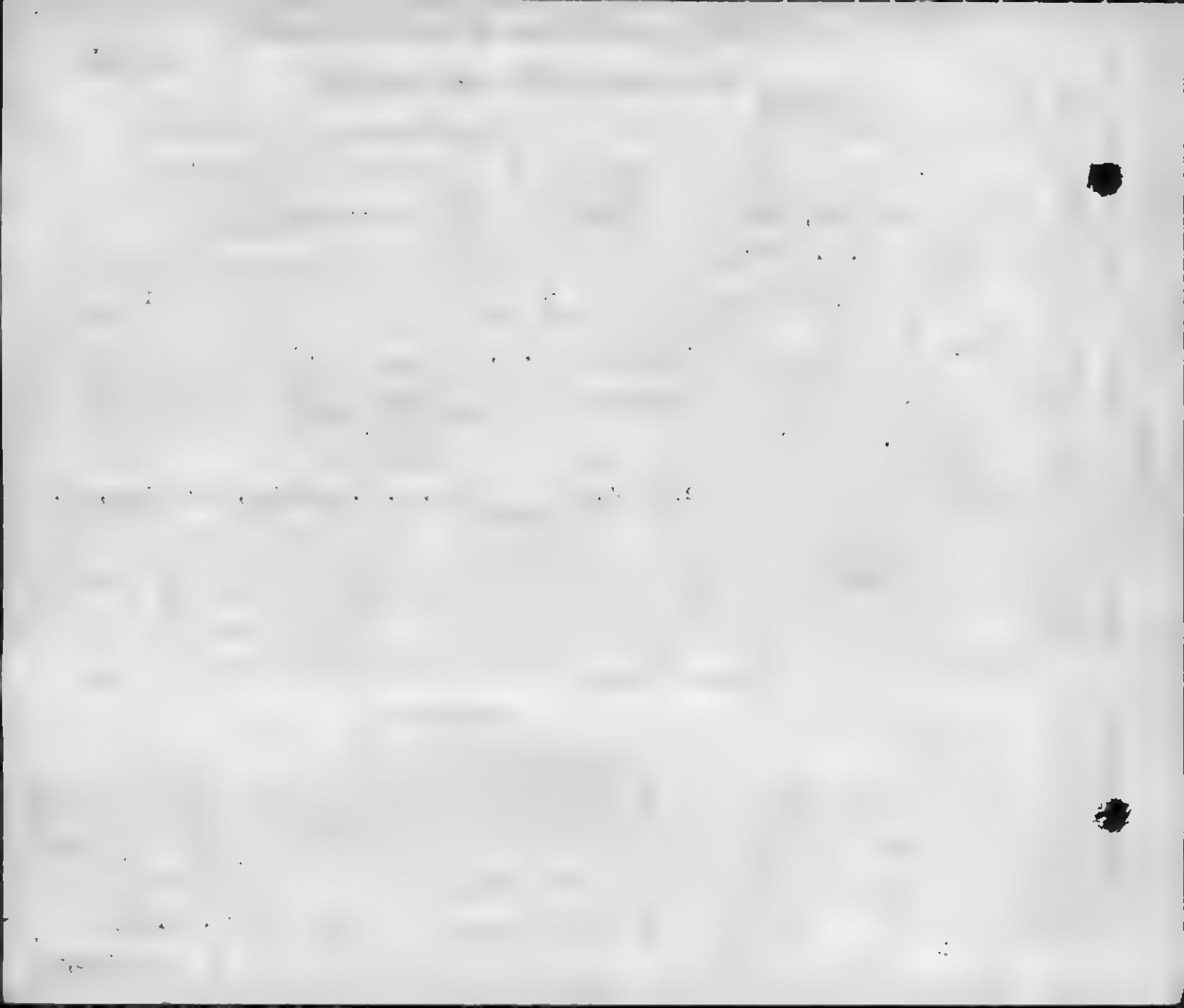
11208

CERTIFICATE OF DEATH

11224

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--------------------------------------|--|-------------------------------|--|--------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Cecil | | MARYLAND | | STATE Maryland | | COUNTY Cecil | |
| CITY (If outside corporate limits, write RURAL OR end give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | STREET ADDRESS | |
| TOWN Perryville, Rural | | Life | | TOWN Perryville | | (If rural give location) | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | U. S. Route #7 | | | | | |
| 3. NAME OF DECEASED (Type or Print) Walter Washington Gillespie | | | | 4. DATE OF DEATH 10 1 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced | 8. DATE OF BIRTH Oct. 2, 1901 | 9. AGE last birthday 56 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if mild) Trainman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Alonzo R. Gillespie | | | | 14. MOTHER'S MAIDEN NAME Mary Geiser | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO | | 16. SOCIAL SECURITY NO. 215-03-7770 | | 17. INFORMANT & ADDRESS Mrs. C. B. Sturgill, Perryville, Md. | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| <p>Coronary Thrombosis, Recurrent Sudden</p> <p>Arteriosclerotic (Arteriolar) Disease</p> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| <p>420.1 IMMEDIATE CAUSE (A)</p> <p>ANTECEDENT CAUSE(S) DUE TO</p> <p>DISEASES OR CONDITIONS, IF ANY, (B)</p> <p>GIVING RISE TO THE ABOVE CAUSE</p> <p>STATING UNDERLYING CAUSE LAST. DUE TO</p> <p>(C)</p> | | | | | | | |
| <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) Port Deposit, Md. | | (County) Carroll | (State) Md. |
| 21d. TIME OF INJURY (Month) Oct. (Day) 1st (Year) 1958 (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| <p>22. I hereby certify that I attended the deceased from DEE 15 1958 to OCT 1st 1958, that I last saw the deceased alive on OCT 1st 1958, and that death occurred at SP, M, from the causes and on the date stated above.</p> <p>SIGNATURE <i>Ward C. Geiser</i> M.D. Address <i>Hurc del place Ind. Oct 2nd 1958 at 1 P.M.</i> DATE SIGNED <i>1958</i></p> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 10/4/58 | | NAME OF CEMETERY OR CREMATORIAL Hopewell Cemetery | | LOCATION (City, town, or county) Port Deposit, Md. Rural | |
| 24. REC'D BY REGISTRAR OCT 6 1958 | | REGISTRAR'S SIGNATURE <i>Ward C. Geiser</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md. | | | |



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10/6/58

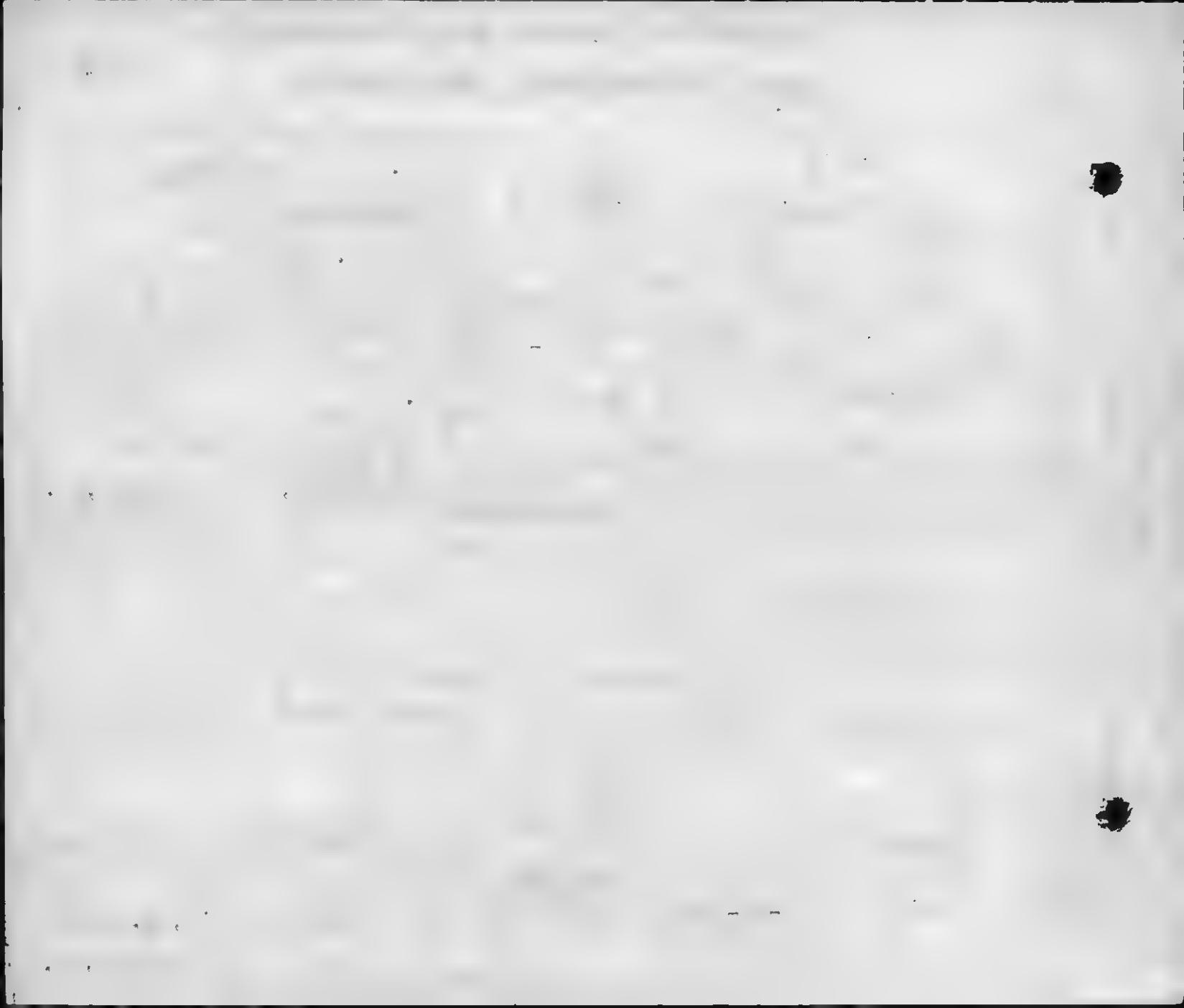
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11209

11225 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN | Cecil Port Deposit | MARYLAND LENGTH OF STAY (in his place) Life | STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Deposit |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | STREET ADDRESS S. Main | | |
| 3. NAME OF DECEASED (Type or Print) | (First) Samuel | (Middle) | (Last) Hasson |
| 4. DATE OF DEATH | (Month) 10 | (Day) 11 | (Year) 1958 |
| 5. SEX Male | 6. COLOR OR White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, Divorced | 8. DATE OF BIRTH 12-7- 1870 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner | 10b. KIND OF BUSINESS OR INDUSTRY U S V Hospital | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME Abraham | 14. MOTHER'S MAIDEN NAME Hasson | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> unk.) (If Yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Norman Hasson, Port Deposit, Md. | |
| 18. MEDICAL CERTIFICATION <i>Cerebral arteriosclerosis -</i> <i>Cystic - sclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <i>Chronic Myocarditis</i> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>July 5, 1958</i> , to <i>Oct. 10, 1958</i> , that I last saw the deceased alive on <i>Oct. 10, 1958</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Clarence F. Knapp, M.D.</i> | | | |
| 23. BURIAL, CREMATION, REMAINS <input checked="" type="checkbox"/> BURIAL | | DATE THEREOF 10-14-1958 | NAME OF CEMETERY OR CREMATORIUM Asbury Cemetery |
| 24. REC'D BY REGISTRAR DATE OCT 14 1958 | | REGISTRAR'S SIGNATURE <i>John J. Kraus</i> | LOCATION (City, town, or county) Port Deposit, Md. Rural |
| 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Lee Patterson, Perryville, Md.</i> | | | |



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

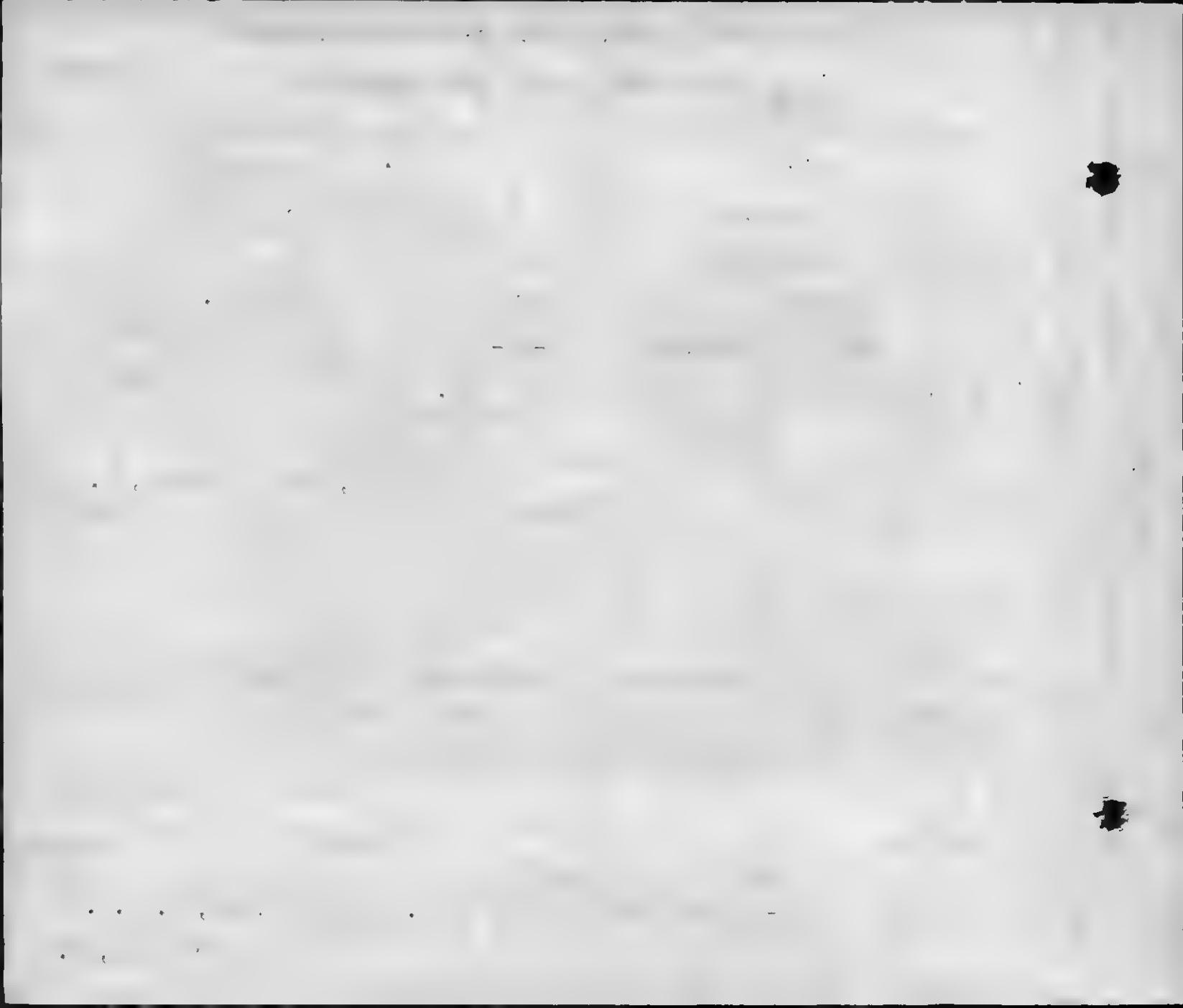
CERTIFICATE OF DEATH

11210

Reg. Dist. No.

11226

| | | | | | |
|---|--------------------------------|---|---|--|---|
| 1. PLACE OF DEATH | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | |
| COUNTY Cecil | | MARYLAND | STATE Md. | | COUNTY Cecil |
| CITY (If outside corporate limits, write RURAL OR give nearest town) | | LENGTH OF STAY (In this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | Perryville, Rural |
| TOWN Port Deposit, Rural | | 1 Month | TOWN | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Cokesbury | | | STREET ADDRESS | | (If rural give location) |
| 3. NAME OF DECEASED (Type or Print) William Henry Hawkins | | | 4. DATE (Month) OR DEATH Oct. 12 1958 (Day) (Year) | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED Widowed | 8. DATE OF BIRTH 11-18-1882 | 9. AGE last birthday 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY Day | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY USA |
| 13. FATHER'S NAME James Hawkins | | | 14. MOTHER'S MAIDEN NAME Margaret Hill | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unk.) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS John Hill, Havre De Grace, Md. R.D. 1 | |
| 18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | 19. MEDICAL CERTIFICATION Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. DATE OF OPERATION | | 21b. MAJOR FINDINGS OF OPERATION | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 1958, 10, Oct 11, 1958 | |
| 22. I hereby certify that I attended the deceased from 1958, 10, Oct 11, 1958, that I last saw the deceased alive on 1958 and that death occurred at M, from the causes and on the date stated above. SIGNATURE <i>Leila Patterson</i> M.D. | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 10-15-1958 | NAME OF CEMETERY OR CREMATORIUM Stewartville Cem. | ADDRESS (Street, city, town, state) Port Deposit, Md. (State) LOCATION (City, town, or county) Havre De Grace, Md. R.D. 1 (State) | |
| 24. REC'D BY REGISTRAR DATE OCT 15 1958 | | REGISTRAR'S SIGNATURE Leila Patterson | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Perryville, Md. | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11210

CERTIFICATE OF DEATH

Reg. Dist. No.

11211

| | | | | | |
|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i> | | c. LENGTH OF STAY IN 1b <i>Life</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>168 St. Main St.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Harry Metzler Farrow (HEVLOW)</i> | | Middle <i>Middle</i> | Last <i>Metzler</i> | 4. DATE OF DEATH <i>October 19th 1958</i> | Month <i>Oct</i> Day <i>19</i> Year <i>1958</i> |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>May 20, 1887</i> | 9. AGE (In years last birthday) 7 yrs IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY (during most of working life, even if retired) <i>Elkton, Md. Merchant</i> | | 11. BIRTHPLACE (State or foreign country) <i>England</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>Frederick Farrow</i> | | 14. MOTHER'S MAIDEN NAME <i>Constance</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO <i>22-0-509</i> | | 17. INFORMANT <i>Donald M. Kee</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) | | <i>Cancer of the lung</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>V. H. McKnight</i> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Oct 20, 1958</i> | | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Gilpin Manor Mem. Pk.</i> | |
| 22d. LOCATION (City, town, or county) <i>Nr. Elkton, Md.</i> | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME <i>Donald M. Kee Elkton, Md.</i> | | | | | |
| ADDRESS DATE <i>Oct 21, 1958</i> | | | | | |
| 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <i>Elkton, Md.</i> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 DEATH MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 18&21 Film 25-2058-81

11212

Reg. Dist. No.

| | | |
|--|----------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | MARYLAND | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | c. LENGTH OF STAY IN 1b 41 FG | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | d. STREET ADDRESS Route 7 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | | | | | |
|---|---------------------------|---|--------------------------------------|---|---|
| 3. NAME OF DECEASED (Type or print) HERBERT | First RAY | Middle HITCHCOCK | 4. DATE OF DEATH Month October | Day 5 | Year 1958 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Aug. 11, 1958 | 9. AGE (In years last birthday) 2 yrs | 10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Elkton, Maryland | |
| 13. FATHER'S NAME Herbert J. Hitchcock | | 14. MOTHER'S MAIDEN NAME Carolina Rae Crouse | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Mrs. Herbert J. Hitchcock | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | Address |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | Bronchopneumonia, probably secondary to aspiration of milk |
| INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

| | | | | | |
|---|--|---|---|-------------------------------|----------|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none | | | | |
| 20c. TIME OF INJURY Hour p. m. 19 | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) Elkton | (County) |
| | | | | | (State) |

21. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

MEDICAL CERTIFICATION

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Paul F. Guerin, M.D.

22a. BURIAL, CREMATION OR
REMOVAL (Specify)
Burial Oct. 8, 1958

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM
Elkton Cemetery

22d. LOCATION (City, town, or county)
Elkton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Pippin Funeral Home Donald M. Jr. Elkton, Md.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

10/6/58

24a. REC'D BY REGISTRAR

DATE OCT 8 58

24b. REGISTRAR'S SIGNATURE

Linus S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11213

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton Rural

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

00

3. NAME OF
DECEASED
(Type or print)

George

First

Paxson

Middle

Kirk

Last

4. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

3-21-1930

9. AGE (In years
from birthday)

78

yrs

10. IF UNDER 16 YEARS

Months

Days

11. IF UNDER 24 HRS

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

Farm owner

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel H. Kirk

14. MOTHER'S MAIDEN NAME

Victoria Paxson Biles

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

220-34-6056

Mrs. Anna Stewart Kirk. Elkton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Acute Coronary

INTERVAL BETWEEN
ONSET AND DEATHConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

Chronic Myocarditis

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour
a. m.
p. m.20d. INJURY OCCURRED
While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

R. C. Do Son, M.D.

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-16-58

22c. NAME OF CEMETERY OR CREMATORIUM

Rosebank

22d. LOCATION (City, town, or county)

(State)

Calvert, Cecil

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

Joseph O. Gray, North East, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE OCT 16 '58

24b. REG. STAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11214

11228

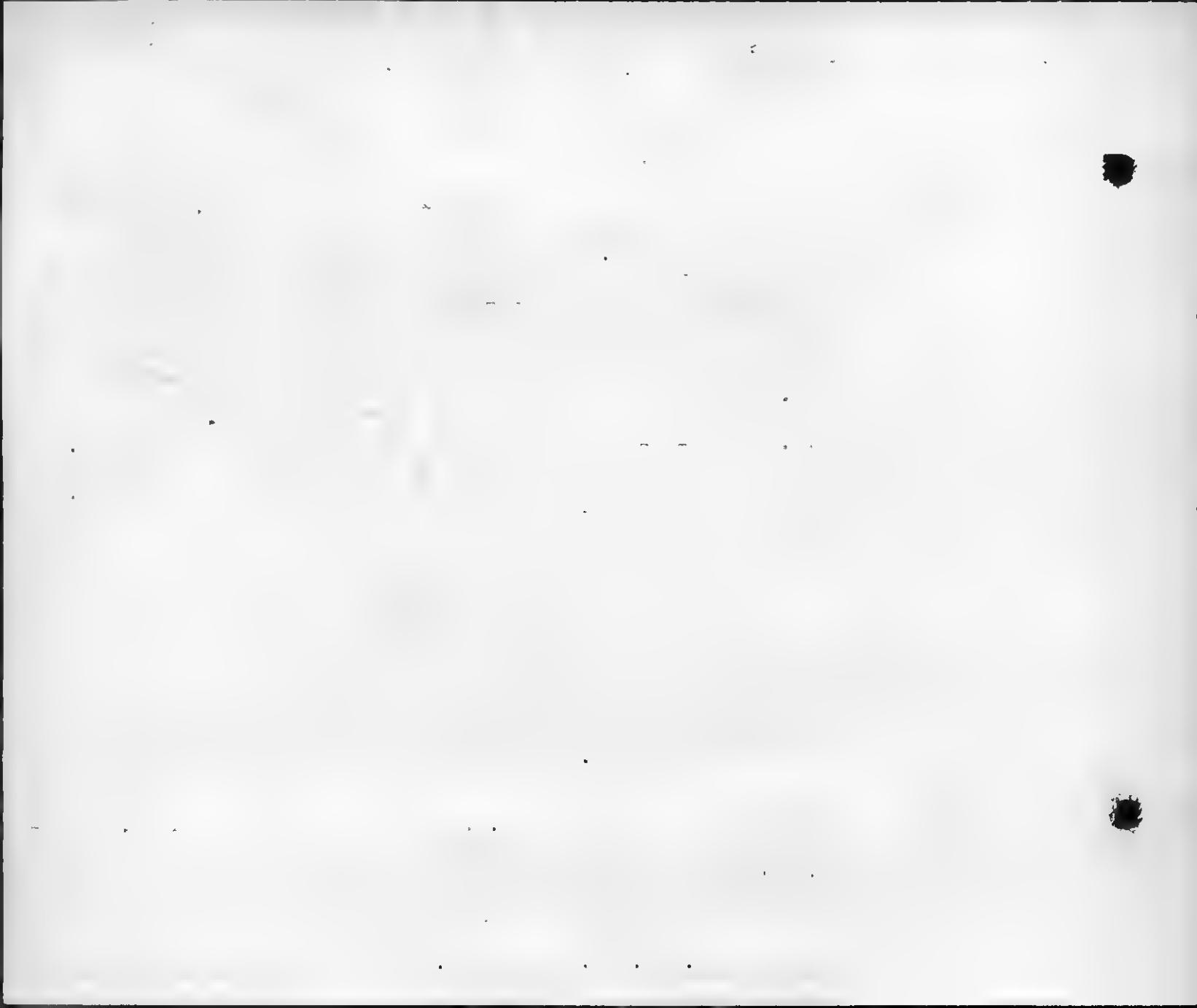
CERTIFICATE OF DEATH

Reg. Dist. No. 96

| | | | | | | | |
|---|----------------------------------|---|---|---|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 1 mo. 10 days | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 2722 - 26th Street, N.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First JAMES | Middle E. | 4. DATE OF DEATH Lay | Month October | Day 14 | Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-1-1878 | 9. AGE (In years last birthday) 80 yrs | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engraver | | 10b. KIND OF BUSINESS OR INDUSTRY Photo | | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME James O. Lay | | 14. MOTHER'S MAIDEN NAME Louise Bower | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO S.A.W. | 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Peritonitis localized, due to extravasated contents of viscera, post-operative Gastrojejunostomy for bleeding ulcer 10-4-58 72 hrs. | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerosis, general, severe (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, general, severe | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis, general, severe | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 11 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) (State) | | | | |
| 21. I certify that I attended the deceased from Sept. 4, 1958, to October 14, 1958, that I last saw the deceased alive on XXXXXXXXX, 19XXXX, and that death occurred at 4:45 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>S. P. L. Cervia</i> | | ADDRESS (Street, city or town, state) Md. V.A. Hospital, Perry Point, Md. | | DATE SIGNED 10-14-58 | | | |
| PHYSICIAN'S NAME (Type) S. P. L. Cervia | | Director, Professional Services | | | | | |
| 22a. BURIAL, Cremation, Removal (Specify) Burial | 22b. DATE THEREOF 10/19/58 | 22c. NAME OF CEMETERY OR CREMATORIUM Arlington National | 22d. LOCATION (City, town, or county) Arlington, Va. | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Malley Fun. Home, 3200 R. I. Ave. Mt. Rainier, Md. | ADDRESS | 24a. REC'D BY REGISTRAR OCT 17 '58 | 24b. REGISTRAR'S SIGNATURE Criswell S. Thomas | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11229

CERTIFICATE OF DEATH

11215

Reg. Dist. No. 96

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | b. COUNTY Cecil | |
| c. LENGTH OF STAY IN 1b Less than 24 hrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 1152 Avenue A | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) CHARLES | | First A. | Middle LEITHISER |
| 4. DATE OF DEATH October 16 1958 | | Month October | Day 16 |
| 5. SEX Male | | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH 4-9-99 | | 9. AGE (in years last birthday) 59 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineering Officer | | 10b. KIND OF BUSINESS OR INDUSTRY V.A. Hospital | 11. BIRTHPLACE (State or foreign country) Havre de Grace, Md. |
| 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13. FATHER'S NAME Isaac Leithiser | | 14. MOTHER'S MAIDEN NAME Catherine Bayard | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Hospital Records, V.A. Hospital, Perry Point |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | INTERVAL BETWEEN ONSET AND DEATH 3-5 days | |
| +5X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. | | Bronchopneumonia, left lower lobe unresolved | |
| (b) DUE TO organism unknown | | 4-6 weeks | |
| (c) DUE TO Multiple abscesses level of C-7 and T-1 | | unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Osteoarthritis of the spine, severe - unknown | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 15, 1958, to October 16, 1958, that deceased was alive on XXXXXXXXXXXXXXXXX, and that death occurred at 7:55 a.m., from the causes and on the date stated above ACTUAL SIGNATURE <i>S. P. LACERVA</i> M.D. V.A. Hospital, Perry Point, Md. 10-16-58 | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) 10/19/58 | | 22b. DATE THEREOF 10/19/58 | 22c. NAME OF CEMETERY OR CREMATORIAL Angel Hill |
| 22d. LOCATION (City, town or county) Havre de Grace, Md. | | (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i> | | 23. ADDRESS Pennington & Son, Havre de Grace, Md. | 24a. REC'D BY REGISTRAR DATE OCT 21 '58 |
| | | 24b. REGISTRAR'S SIGNATURE <i>C. L. Knudsen</i> | |



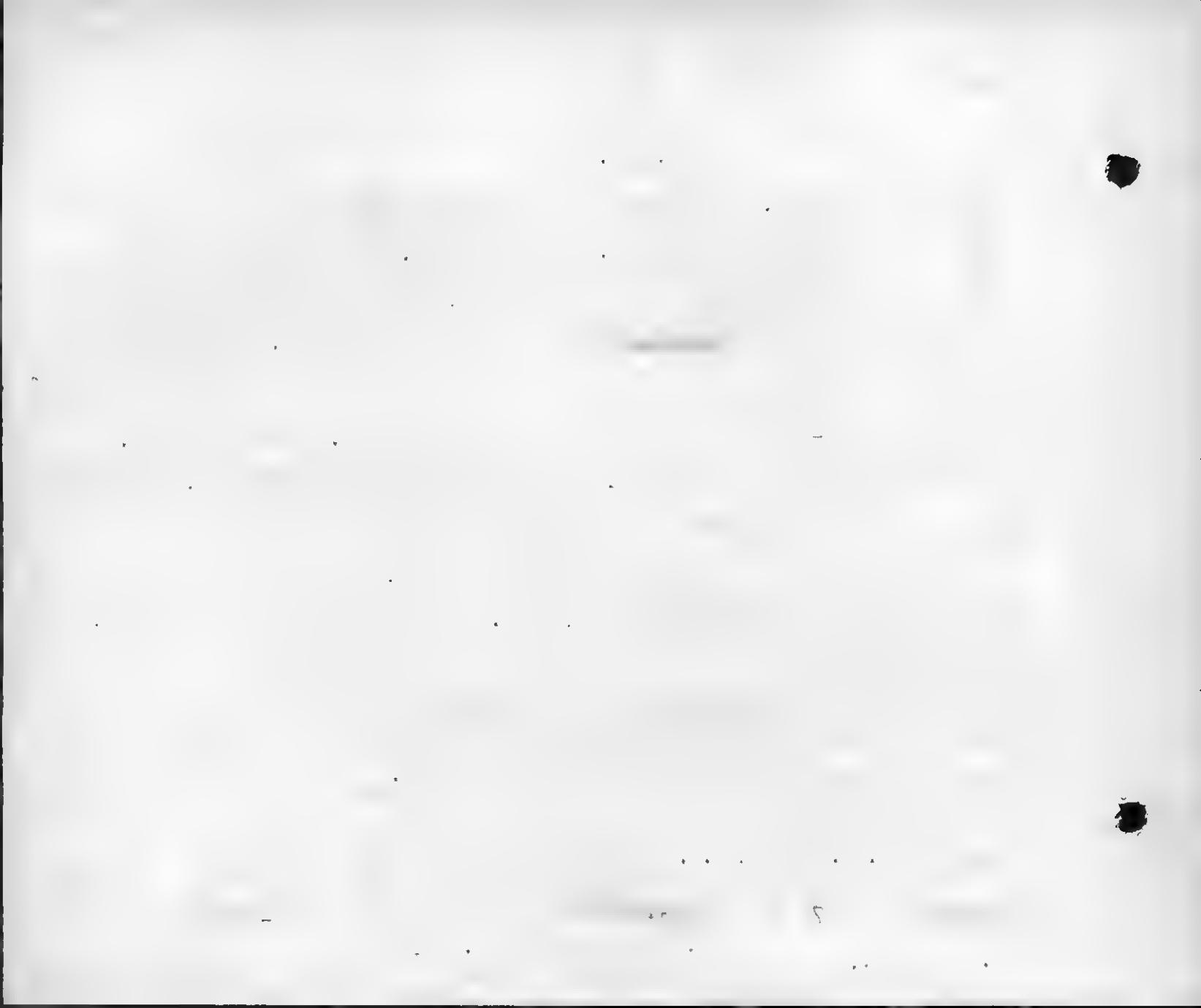
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11230 CERTIFICATE OF DEATH

11216
 Reg. Dist. No.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 2 yrs. 2 mos. 20 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First H. | Middle LLOYD |
| 4. DATE OF DEATH October 2 1958 | | Last Jr. | Month October |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1893 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist | | 10b. KIND OF BUSINESS OR INDUSTRY McCambridge Chem- ical Company | 11. BIRTHPLACE (State or foreign country) Chesapeake City, Md. |
| 13. FATHER'S NAME WILLIAM LLOYD | | 14. MOTHER'S MAIDEN NAME ELIZABETH LEIBOLD | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes | | 16. SOCIAL SECURITY NO. WW-1 | 17. INFORMANT Unknown Hospital Records, VAH., Perry Point, Md. |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | INTERVAL BETWEEN ONSET AND DEATH 2 to 5 days | |
| Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Brain Disease | | DUE TO Bronchopneumonia, right lower lobe, unresolved. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerosis, generalized, severe. | | DUE TO Cerebral arteriosclerosis, severe | |
| Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized, severe. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 12, 1956 , to October 2, 1958 , and that death occurred at 8:35 A.M. , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) W. M. Harris, M.D. | |
| ACTUAL SIGNATURE W. M. Harris | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D., Acting Director, Professional Services | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10-7-58 | 22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National | 22d. LOCATION (City, town, or county) Baltimore (State) Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. COOK, Inc., | | 24a. ADDRESS St. Paul & Preston Ave. | 24b. REC'D BY REGISTRAR OCT 6 '58 |
| | | DATE OCT 6 '58 | REGISTRAR'S SIGNATURE C. Hart S. Thomas |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11217

11212

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|---|---------------------------------|--|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 3 day | | b. COUNTY Cecil | | TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union | | d. STREET ADDRESS North East Rural | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | First Martha | Middle Jane | Last Mathis | 4. DATE OF DEATH 10 | Month 10 | Day 14 | Year 1958 |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-22- 1892 | 9. AGE (In years last birthday) 65 yrs. | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS Days 0 | 12. IF UNDER 24 HRS Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James T. Buchanan | | | | 14. MOTHER'S MAIDEN NAME Sarah L. Williams | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | | 16. SOCIAL SECURITY NO NO 160-01-6973 | | 17. INFORMANT Charles S. Mathis Port Deposit Route 3 Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) | | | | Acute Coronary Occlusion with myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Hour a. m. — 19 p. m. — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) — (State) — | |
| 21. I certify that I attended the deceased from 8 Oct, 1958, to 14 Oct, 1958, that I last saw the deceased alive on 14 Oct, 1958, and that death occurred at 7:35 P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Klaus H. Huchner | | M.D. | | ADDRESS (Street, city or town, state) No. 14 East Rd | | DATE SIGNED 14 Oct '58 | |
| PHYSICIAN'S NAME (Type) Klaus H. Huchner A.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-18-1958 | | 22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Presby | | 22d. LOCATION (City, town, or county) Rising Sun Rural Cecil Co., Md (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Gray | | ADDRESS North East, Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 20 '58 | | 24b. REGISTRAR'S SIGNATURE Cecil S. Huchner | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218

11231

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | |
|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake City</i> | | c. LENGTH OF STAY IN 1b <i>Life</i> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Morgan Nursing Home</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | First <i>Freeman</i> | Middle <i></i> | Last <i>Morgan</i> | |
| 4. DATE OF DEATH | Month <i>October</i> | Day <i>6</i> | Year <i>1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>October 6, 1875</i> | |
| 9. AGE (In years less birthday) <i>83 yrs.</i> | 10. IF UNDER 1 YEAR Months <i></i> | 11. IF UNDER 24 HRS. Days <i></i> | 12. IF UNDER 24 HRS. Hours <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Corp of Engineers</i> | 10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i> | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>James W. Morgan</i> | 14. MOTHER'S MAIDEN NAME <i>Rachel Freeman</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | 16. SOCIAL SECURITY NO. <i>None</i> | 17. INFORMANT <i>Mrs. Rebecca M. Davitt, Baltimore 18, Md</i> | Address 903 Belgian Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion, acute</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> | | |
| DUE TO <i>400.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Coronary Sclerosis</i> | | DUE TO <i>unknown</i> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i> | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Oct 5, 1958</i> to <i>Oct 6, 1958</i> , that I last saw the deceased alive on <i>Oct 6, 1958</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above. | | | | |
| ACTUAL SIGNATURE <i>Wallace Oberman</i> | M.D. <i>Cecilton, Md.</i> | | ADDRESS (Street, city or town, state) <i></i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>10/9/58</i> | 22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Bethel, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i> | | ADDRESS <i>Elkton, Md.</i> | 24a. REC'D BY REGISTRAR DATE <i>Oct 14 '58</i> | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i> |



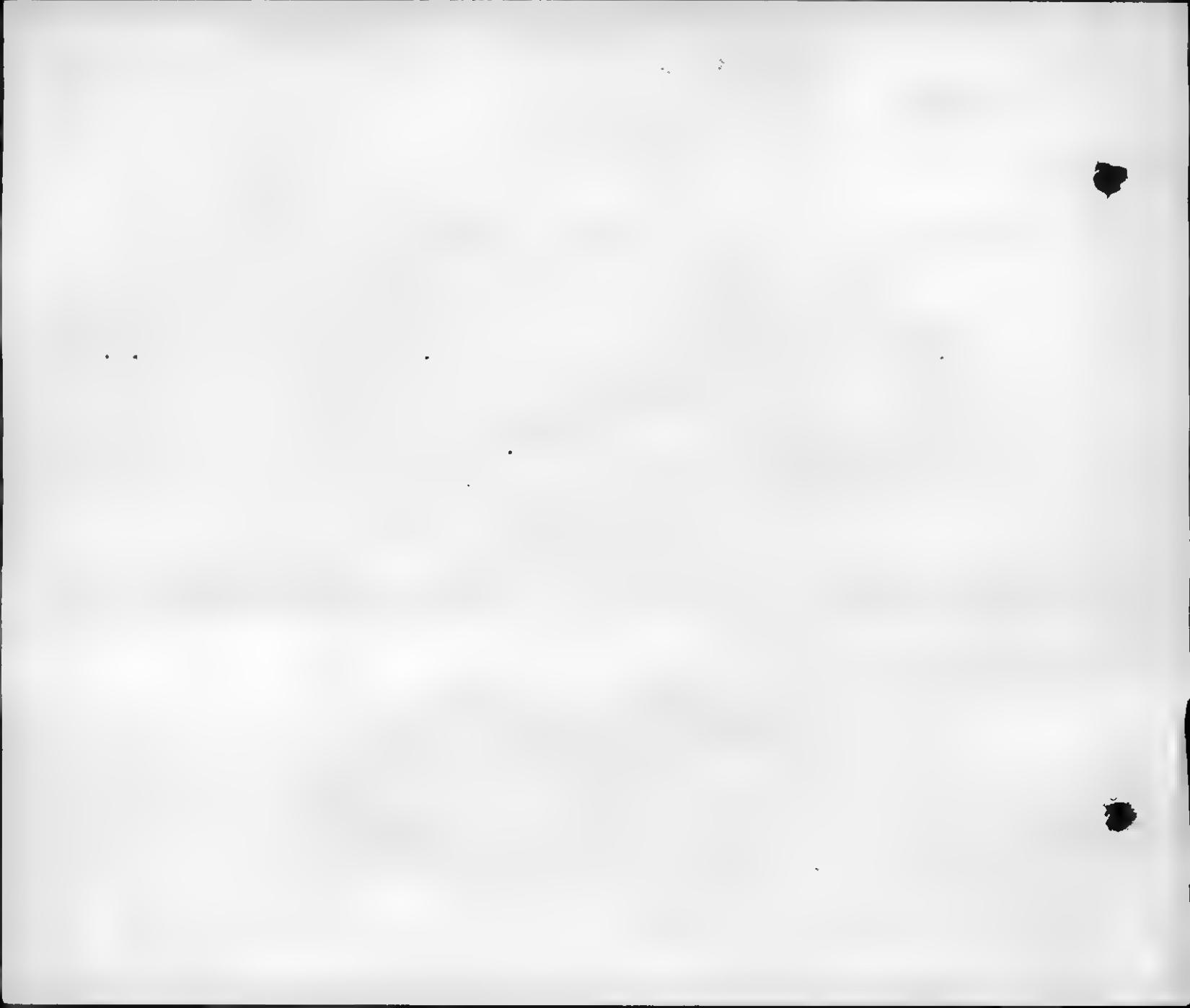
TO DEPUTY MEDICAL EXAMINER: This cert. of death should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for our files.
 TO FUNERAL DIRECTOR: Page 1 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11219

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyons Corner | | c. LENGTH OF STAY IN 1b 15 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake City, Md. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lyons Corner | |
| 3. NAME OF DECEASED (Type or print) First Benjamin Nuble | | 4. STREET ADDRESS Chesapeake City, Md. | |
| 5. SEX M | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 9-11- 1930 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 9. AGE (In years last birthday) 78 | |
| 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Solomon Nuble | | 14. MOTHER'S MAIDEN NAME Mary A. Richards | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Ben. Nuble, Chesapeake City | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | 19. INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>R. C. Dobson</i> | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 10-12-53 |
| 22a. BURIAL CREMATION REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/18/58 | 22c. NAME OF CEMETERY OR CREMATORIUM Bohemia Manor Cem. | 22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edu P. Bell</i> | ADDRESS Wilm. Del. | 24a. REC'D BY REGISTRAR DATE 15 1958 | 24b. REGISTRAR'S SIGNATURE <i>Charl. S. Kraus</i> |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11220

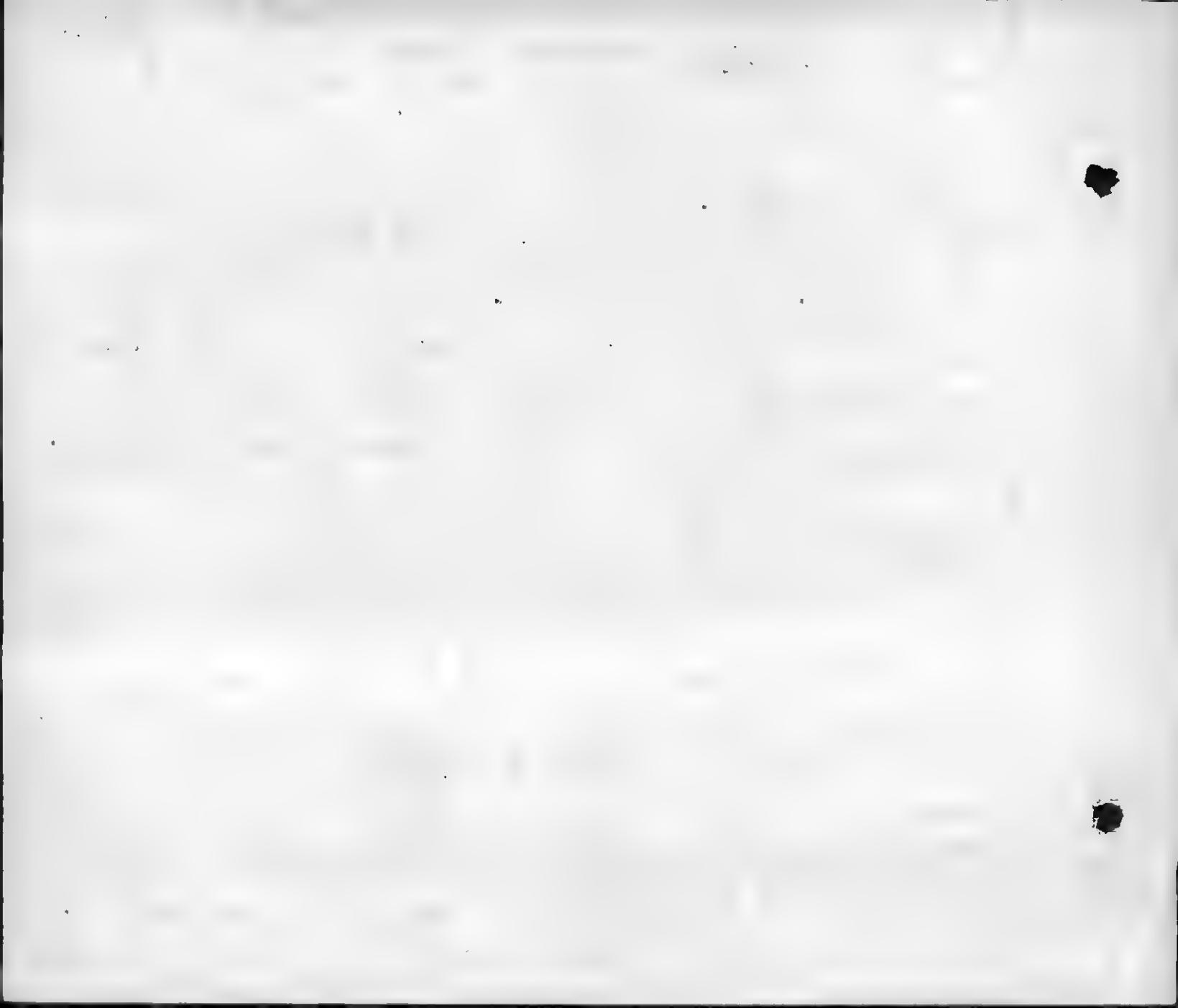
11213

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 2 Hrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | |
| 3. NAME OF DECEASED (Type or print) Baby | | First Middle Boy | 4. DATE OF DEATH Oct. 12 |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Oct. 12, 1958 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 10c. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? u.s.a. | |
| 13. FATHER'S NAME Raymond Raison | | 14. MOTHER'S MAIDEN NAME Ida Mae Garnet | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT Raymond Raison | | Address Chesapeake City, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Respiratory paralysis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 12, 1958</u> to <u>Oct 12, 1958</u> , that I last saw the deceased alive on <u>Oct 12, 1958</u> , and that death occurred at <u>801 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Henry J. Davis M.D.</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <u>Henry J. Davis M.D.</u> DATE SIGNED <u>Oct 12, 1958</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 15, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL Bohemia Manor | | 22d. LOCATION (City, town, or county) N. Chesapeake City, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home | | ADDRESS Dodd St. Elkton, Md. | |
| 24a. REC'D BY REGISTRAR OCT 17 '58 | | 24b. REGISTRAR'S SIGNATURE <u>C. T. Evans</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



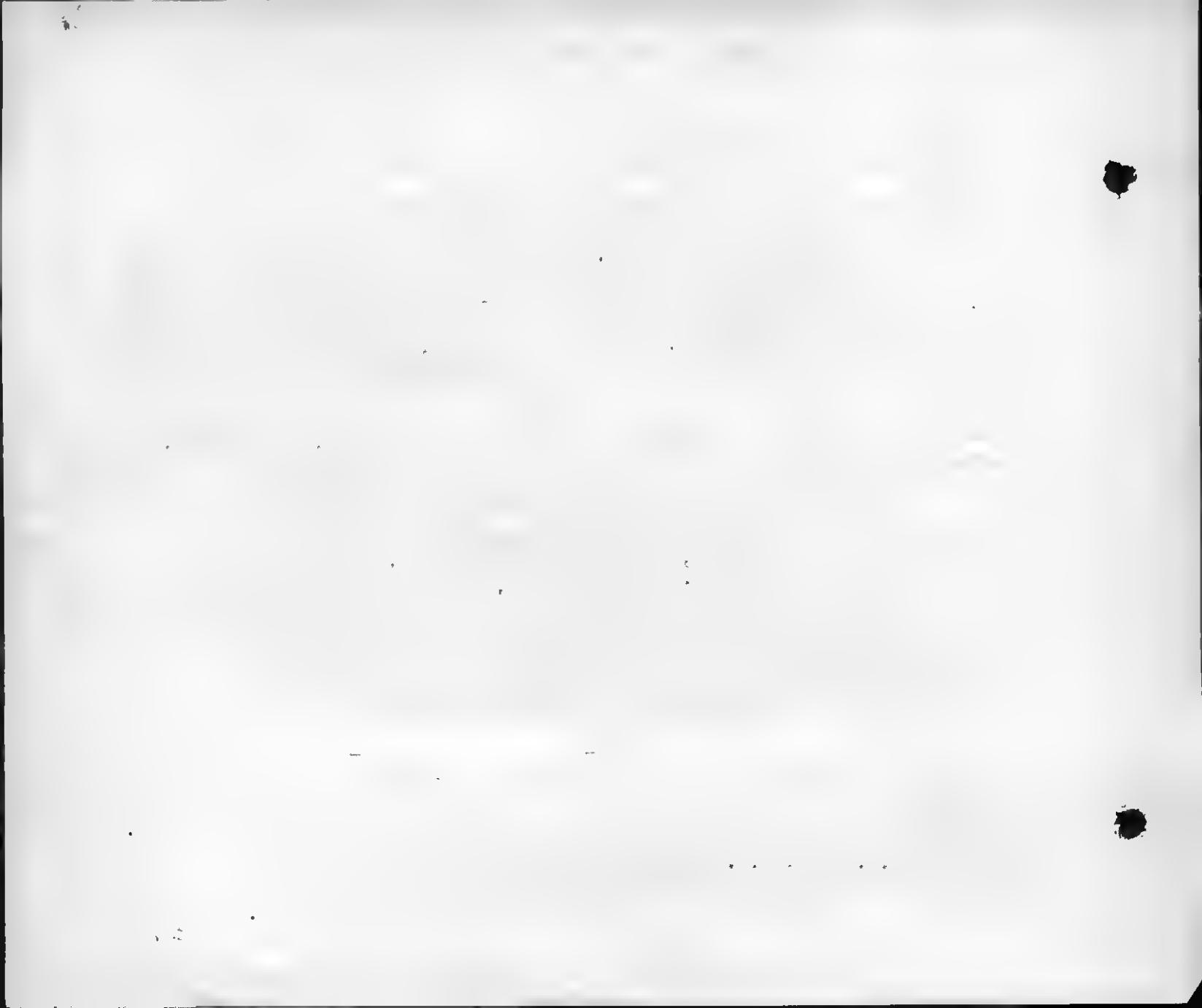
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11221

11233 CERTIFICATE OF DEATH Reg. Dist. No. 96

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|--|---|---------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland | | b. COUNTY Hartford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland | | c. LENGTH OF STAY IN 1b 21 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace | | d. STREET ADDRESS 556 Franklin Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | First WILLIAM | Middle E. | Last SARVER | 4. DATE OF DEATH | Month 10 | Day 12 | Year 1958 |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 10-3-11 | 9. AGE (In years from birth) 47 yrs | IF UNDER 1 YEAR Months 47 | IF UNDER 24 HRS Days 0 | Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Concrete Finisher | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Bastin, Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FRANK M. SARVER | | | | 14. MOTHER'S MAIDEN NAME LILLY STEELE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes | | 16. SOCIAL SECURITY NO. 517 09 1676 | | 17. INFORMANT Hospital Records, VAH, Perry Point, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 179.2. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO Carcino matosis, adenocarcinoma, metastatic to lungs, mediastinal lymph nodes, & abdominal lymph nodes. Origin obscure. | | | | INTERVAL BETWEEN ONSET AND DEATH 4 To 5 Days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that E.S. Ellis attended the deceased from 9-21-1958 to 10-12-1958 , and that death occurred at 6:15 AM , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md. DATE SIGNED 10-12-58 | | | | | | | |
| ACTUAL SIGNATURE E.S. Ellis M.D. V.A. Hospital, Perry Point, Md. 10-12-58 | | | | | | | |
| PHYSICIAN'S NAME (Type) E.S. Ellis, M.D., Acting Director, Professional Services | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 10-13-58 | | 22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill | | 22d. LOCATION (City, town, or county) Bastian, Va. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Remington, Havre de Grace, Md. | | | | ADDRESS Havre de Grace, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 17 58 | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE John E. Haas | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11222

11214

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> | | 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EIKTON</i> | | c. LENGTH OF STAY IN 1b <i>21</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EIKTON</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Billy Ray Sheets.</i> | | 4. DATE OF DEATH <i>Oct. 27 1958</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>October 27 1938</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>mane</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>-</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>EIKTON, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>James Roger Sheets, Sr.</i> | | 14. MOTHER'S MAIDEN NAME <i>Callie Estridge</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>776X</i> | | 16. SOCIAL SECURITY NO. <i>0-776-42-1234</i> | |
| 17. INFORMANT <i>James Roger Sheets, Sr.</i> | | Address <i>R.D. # 1 EIKTON, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>776X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i> DUE TO <i>(c)</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>90 min.</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/> 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Oct. 27, 1958</i> to <i>Oct. 27, 1958</i> , that I last saw the deceased alive on <i>Oct. 27, 1958</i> , and that death occurred at <i>6:23 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Oneida H. Precher</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>10-28-58</i> | |
| 22c. NAME OF CEMETERY OR CREMATORIAL PK. <i>Gilpin Manor Memorial PK.</i> | | 22d. LOCATION (City, town, or county) (State) <i>R.D. # 1 EIKTON Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. M. Pippin Funeral Home W. A. Lusby</i> | | ADDRESS <i>259 E. Main St. EIKTON, Md.</i> | |
| 24a. REC'D BY REGISTRAR DATE <i>OCT 29 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>James S. Evans</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11223

11215

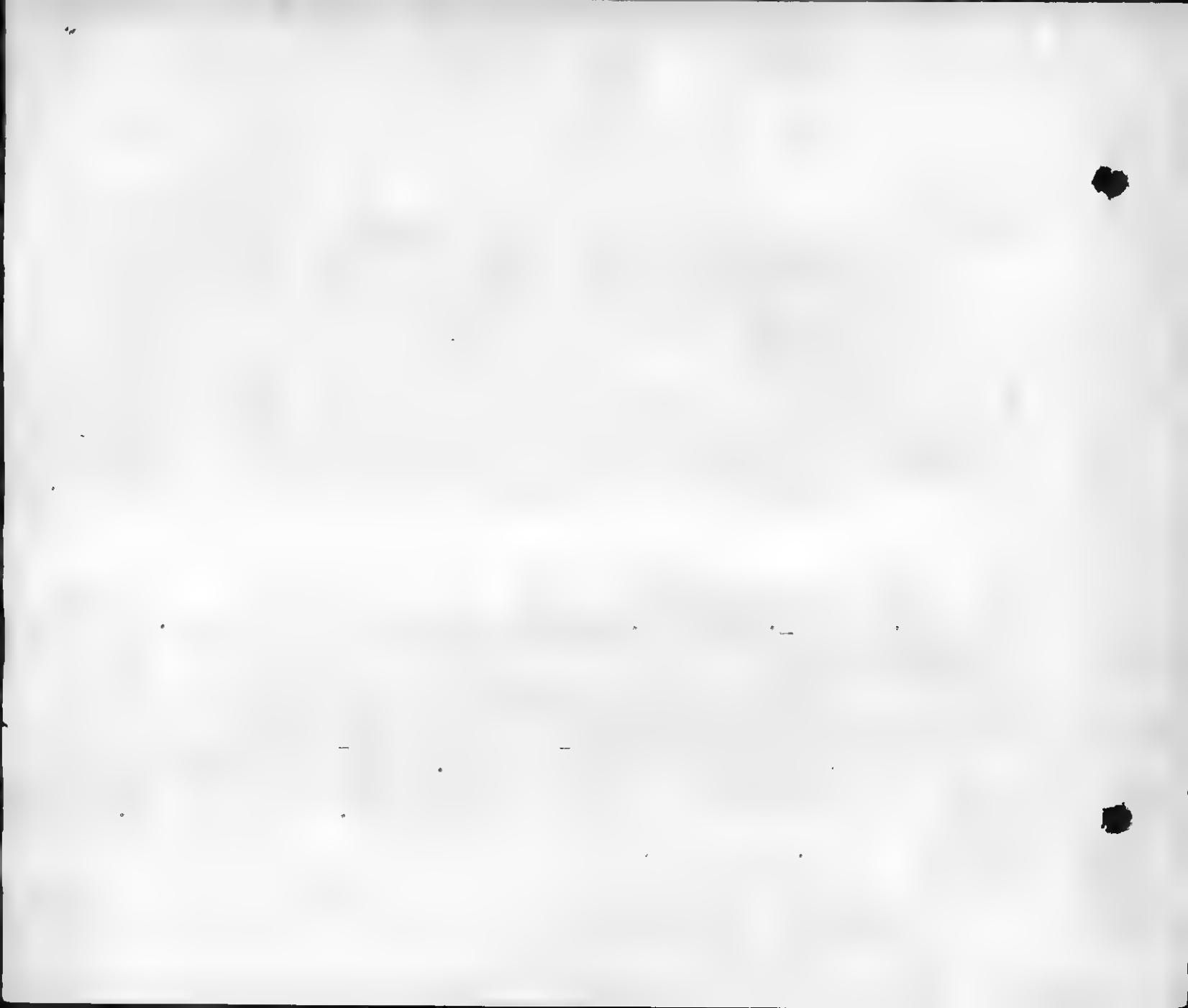
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|---|---------------------------------------|---|-------------------------------|---|----------|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 1 day | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First William | Middle Charles | | | | |
| 3. NAME OF DECEASED (Type or print) | | Last Shivery | 4. DATE OF DEATH 10 13 19 58 | | | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 12-6-1911 | 9. AGE (In years lost birthday) 46 yrs. | 10. IF UNDER 1 YEAR Months | 11. IF UNDER 24 HRS. Days | 12. Year |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer | | 10b. KIND OF BUSINESS OR INDUSTRY Sparklers | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Harry Shivery | | 14. MOTHER'S MAIDEN NAME Adelaide Dick | | Address | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO 216-01-4591 | | 17. INFORMANT Mrs Irene Reid Shivery Perryville, RD Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 57dx | | Myocardial failure | | INTERVAL BETWEEN ONSET AND DEATH 30 mints | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) | | Uremia | | 24 hours | | | |
| DUE TO (c) | | Chronic interstitial nephritis | | years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronch. Asthma c. Emphysema, Duodenal Ulcer, Cardiac Decompens. | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10-12-1958, to 10-13-1958, that I last saw the deceased alive on 10-12-1958, and that death occurred at 1:25 a.m. from the causes and on the date stated above. ACTUAL SIGNATURE Luis M. Cuza, M.D. | | ADDRESS (Street, city or town, state) Cecil Ave. North East, Md. 10-13-58 | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-15-1958 | | 22c. NAME OF CEMETERY OR CREMATORIUM St Mary Ann | | 22d. LOCATION (City, town or county) North East, Cecil Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant | | ADDRESS North East, Maryland | | 24a. REC'D. BY REGISTRAR OCT 16 1958 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thrall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11224

11216

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md. | | c. LENGTH OF STAY IN lb 30 Years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.F.D. #3 | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mae | | First C. | Middle Smith |
| 4. DATE OF DEATH October | Month 14, | Day 19 | Year 58 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 1, 1891 |
| 9. AGE (In years last birthday) 67 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife | | 10b. KIND OF BUSINESS OR INDUSTRY at Home | 11. BIRTHPLACE (State or foreign country) Delaware |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Frank Thompson | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Moran | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO None | | 17. INFORMANT Mrs. Pauline R. Smith Wilm, Del. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 | | INTERVAL BETWEEN ONSET AND DEATH 24 days | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hypertension | | unknown | |
| DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 20, 1958, to Oct. 14, 1958, that I last saw the deceased alive on Oct. 14, 1958, and that death occurred at 2:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i> | | ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland DATE SIGNED 10/15/58 | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 18, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORIUM Immaculate Conception | | 22d. LOCATION (City, town, or county) Elkton, Md. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home | | ADDRESS Elkton, Md. | |
| | | 24a. REC'D BY REGISTRAR PCT 17 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kinney | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 6236 11-20-58 et

11217

CERTIFICATE OF DEATH

11225

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY CECIL | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. LENGTH OF STAY IN 1b 17 RYOMO | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RISING SUN | |
| 3. NAME OF DECEASED (Type or print) ELIZABETH | | First R | Middle STEPHENS |
| 4. DATE OF DEATH OCT 26 1958 | | Month Oct | Day 26 |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH DEC, 10, 1863 | | 9. AGE (In years last birthday) 94 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESS MAKER | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) RISING SUN, MD. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOSEPH L. STEPHENS | |
| 14. MOTHER'S MAIDEN NAME V. H. Rutledge | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO | |
| 16. SOCIAL SECURITY NO. NOME | | 17. INFORMANT Mrs Edwin Haines, Rising Sun, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic cardiovascular disease unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe generalized rheumatoid arthritis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 10, 1957 to October 26, 1958, that I last saw the deceased alive on Oct. 24, 1958, and that death occurred at 1:40a.m., from the causes and on the date stated above. ACTUAL SIGNATURE S. Ralph Andrews, Jr. | | ADDRESS (Street, city or town, state) 233 E. Main Street Elkton, Maryland DATE SIGNED October 26, 1958 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10/29/58 | |
| 22c. NAME OF CEMETERY OR CREMATORIAL ROSE BANK | | 22d. LOCATION (City, town, or county) CALVERT MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed | | 24a. REC'D BY REGISTRAR DATE OCT 28 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

CERTIFICATE OF DEATH

1013

JULIA M. HARRIS, deceased, born 12-18-1879, died 1-15-1950.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11218

CERTIFICATE OF DEATH

11226

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. LENGTH OF STAY IN 1b 21 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | |
| 3. NAME OF DECEASED (Type or print) WILLIAM | | First HENRY | Middle WESSEL JR. |
| 4. DATE OF DEATH OCT. 14 | | Last 1958 | Month Day Year |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAR. 25-1899 |
| 9. AGE (In years last birthday) yrs. 59 | 10. IF UNDER 1 YEAR Months 0 | 11. IF UNDER 24 HRS. Days 0 | 12. IF UNDER 24 HRS. Hours 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD | | 10b. KIND OF BUSINESS OR INDUSTRY FIREWORKS PLANT | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WM. H. WESSEL | | 14. MOTHER'S MAIDEN NAME LILLIAN BLAND | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. 214-208686 | |
| 17. INFORMANT PERRY Wessel | | Address CHESTERTOWN | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH none | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). (b) Arteriosclerotic cardiovascular disease DUE TO unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | Month 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Jan. 26, 1958, to Oct. 14, 1958, that I last saw the deceased alive on Oct. 14, 1958, and that death occurred at 4:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D. | 233 E. Main Street Oct. 14, 1958 | | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | Elkton, Maryland | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF Oct. 17 | 22c. NAME OF CEMETERY OR CREMATORIAL CHURCH HILL | 22d. LOCATION (City, town, or county) CHURCH HILL MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane | ADDRESS Church Hill Md. | 24a. REC'D BY REGISTRAR OCT 21 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

